LEGISLATIVE FISCAL OFFICE
Streamlining Commission Analysis

Recommendation No. **RECOMMENDATION 167**

Streamlining Draft **AGMARTIN 27**

Date: February 17, 2010 1:06 PM
Author:
Dept./Agy.: LSU/HCSD
Subject: Absorption of State Hospital Patients by Comm. Hospitals
Analyst: Charley Rome

Absorption of State hospital patients by community hospitals with a renewed investment being made in outpatient and primary care access. Huey P. Long Medical Center should be the first to be evaluated under this policy.

Inpatient capacity can be absorbed by the community hospitals in certain markets, with a renewed investment being made in outpatient and primary care access. These models should be evaluated immediately by Department of Health and Hospitals, Louisiana State University and Louisiana State University Health Care Services Division on a case by case basis in each community, and the study should be completed by December 31, 2010. In those communities where these models would be successful, the state should evolve the system to meet the needs of that community while optimizing the existing complement of non-public beds in that market. Huey P. Long Medical Center should be the first to be evaluated under this policy and an RFP should be written to outsource the acute and inpatient care for that Medical Center while planning for an outpatient clinic either within the current Huey P. Long Medical Center structure or using private providers using the DSH funds available in the future allocated between the inpatient and outpatient services.

EXPENDITURES	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**5 -YEAR TOTAL**
State Gen. Fd.	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN	
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN	
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

REVENUES	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**5 -YEAR TOTAL**
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

EXPENDITURE EXPLANATION

The Commission's recommendation will have an unknown effect on state expenditures. The State's charity hospitals receive a higher Medicaid acute reimbursement per day compared to community or private hospitals operating in the same areas. According to LSU, Medicaid rates at state hospitals are higher than community and private hospitals because community and private hospitals can shift unfunded Medicaid costs to private insurance patients. State charity hospitals cannot shift Medicaid costs to private insurance patients because state hospitals treat few private insurance patients. Given this explanation on why Medicaid per diem rates are higher in State hospitals, a recent analysis by the Legislative Fiscal Office (LFO) found an average estimated savings of approximately $950 per day for patients treated in nearby community hospitals compared to inpatient treatment costs in State charity hospitals. This estimate was based on FY09 data for approximately 107,000 Medicaid patient days in state charity hospitals and would result in an estimated annual savings of $102 million in Medicaid expenditures if all state Medicaid patients were treated in nearby hospitals. These estimated savings presume there is adequate bed and specialist capacity in nearby hospitals and that such hospitals will accept Medicaid patients. Timely information on available capacity in private hospitals is unavailable from LSU, the Health Care Services Division (HCSD), the Department of Health and Hospitals (DHH), or the Louisiana Hospital Association (LHA). DHH also reports that many smaller hospitals do not have enough specialists to provide comprehensive care for affected patients and such hospitals often transfer sicker and higher cost patients to hospitals providing more comprehensive care. DHH also reports that funding to treat such patients often remain with the initial hospital and physicians and hospitals providing comprehensive care often go without payment for services.

The Commission's recommendation relative to inpatient treatment of indigent (Uncompensated Care/"UCC") patients and related costs are unquantifiable at this time. HCSD hospitals treat a large number of indigent patients with state and federally funded UCC funds. In the absence of state charity hospitals, indigent patients will seek care at private hospitals in the state. The first step in any comparative analysis with regard to the cost-effectiveness of UCC would be to determine where indigent patients are actually seeking care and then determine the current costs per patient based on those expenditures. Information to ascertain these impacts is not available.

REVENUE EXPLANATION

There is no anticipated direct material effect on governmental revenues as a result of this measure.

Senate Dual Referral Rules

☐ 13.5.1 >= $500,000 Annual Fiscal Cost

☐ 13.5.2 >= $500,000 Annual Tax or Fee Change

House

☐ 6.8(F) >= $500,000 Annual Fiscal Cost

☐ 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease

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CONTINUED EXPLANATION from page one:

(Expenditure Explanation Continued from Page One)

In the absence of patient level UCC data, it is still possible to make some general inferences relative to UCC reimbursement of HCSD hospitals compared to non-rural community hospitals. Historically, the state has reimbursed HCSD hospitals and rural community hospitals based on 100 percent of reported costs compared to reimbursement of non-rural community hospitals at an amount less than 100 percent based on a formula in HB 1 described below. As such, aggregate UCC payments will likely decrease by unknown amounts if indigent patients seek care in non-rural community hospitals instead of HCSD hospitals. In the general appropriations bill, the Legislature appropriates UCC payments to non-rural community hospitals at the following amounts:

1. If the hospital's qualifying uninsured cost is less than 3.5 percent of total hospital cost, no payment shall be made;
2. If the hospital's qualifying uninsured cost is equal to or greater than 3.5 percent of total hospital cost but less than 6.5 percent of total hospital cost, the payment shall be 50 percent of an amount equal to the difference between the total qualifying uninsured cost as a percent of total hospital cost and 3.5 percent of total hospital cost;
3. If the hospital's qualifying uninsured cost is equal to or greater than 6.5 percent of total hospital cost but less than or equal to 8 percent of total hospital cost, the payment shall be 80 percent of an amount equal to the difference between the total qualifying uninsured cost as a percent of total hospital cost and 3.5 percent of total hospital cost;
4. If the hospital's qualifying uninsured cost is greater than 8 percent of total hospital cost, the payment shall be 90 percent of qualifying uninsured cost for the portion in excess of 8 percent of total hospital cost and 80 percent of an amount equal to 4.5 percent of total hospital cost.

The Legislative Fiscal Office is unable to ascertain the fiscal impacts from the Commission's recommendation for "renewed investment being made in outpatient and primary care access". There is no way to estimate costs to house and staff outpatient and primary care access as recommended by the Commission without more specifics on the number of patients and corresponding care needs. Federal law requires that emergency departments at all hospitals treat patients with emergencies, but does not require that private hospitals treat non-emergent conditions for patients without coverage or the means to pay for treatment. The appropriate setting for care of these chronic diseases is a doctor's office, but most doctors will not schedule uninsured patients unless they can pay up front. Correspondingly, the state's charity hospitals treated approximately 1.3 million patients in outpatient clinics in 2008 and HCSD reported spending nearly half of its uncompensated care (UCC) funding in 2008 ($191 million) on outpatient services for indigent patient with no other care options. As such, outpatient care for chronic conditions like diabetes, heart disease, and acute conditions like cancer will often be unavailable in the absence of outpatient and primary care provided in state charity hospital clinics because there is no known funding mechanism to provide such care outside the clinics run by the state's charity hospitals.

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